Children's Disability Workgroup Preliminary Summary of Activities, Findings & Recommendations - DRAFT

Source: TAC, DHS, Workgroup
Date Created: October 10, 2011

Charge to the Workgroup

- Redesign of publicly funded children's disability services
- This includes but is not limited to attending to the needs of children placed in out-of-state residential treatment programs due to a lack of services in the state
- An analysis of gaps in the children's system
- Identify steps necessary to develop an integrated delivery of services across multiple systems
- Deliver an interim report to the Legislature in 2011
- Complete a final proposal on or before December 10, 2012

Workgroup Activities

1. Gap Analysis

- There are no clearly defined, titled, accessible, logical pathways into treatment for children and their families
    - How to access services varies by community
    - There is no macro-level knowledge of or accountability for children's disability services
- Kids get "what we have" rather than "what they need"
    - Not enough service nuance and variety to give kids and families, in an individualized way, what they need
    - The system is not nimble
    - There is inadequate attention to assuring developmentally-appropriate services
    - Inadequate attention to building "specialized" competencies
- The unique needs of parents, guardians, caretakers and family members is not adequately addressed

    - No formalized means for assistance in navigating very complex system
    - Limited expertise in supporting, partnering with, and understanding the journey of parents of children with disabilities
- PMIC services are not providing optimal impact due to disconnect with community-based services, reimbursement practices, and insufficient care/continuity management
- Lack of timely access to key services delays care, risks harm and contributes to demand for out-of-state care
    - Waiver (extensive wait list for service that requires child meet criteria for "hospital" hospital level of care")
    - PMIC bed (children housed in shelter and inpatient hospital beds awaiting treatment)
- 24/7/365 in-community, resolution-focused, crisis intervention, support and brief stabilization for children and families is largely unavailable throughout the state
    - Results in overuse of more restrictive, intensive services (hospital emergency departments, inpatient hospitalization, residential treatment, law-enforcement-involvement, involuntary commitments or other court orders)
    - Increased penetration into Child Welfare and Juvenile Justice system
- Child-serving systems are disconnected. Care is not coordinated. Services are delivered and outcomes are measured at a program rather than system level
    - No common values or guiding principles in meeting the health needs of children and families
    - No mechanisms for pulling people/services/systems together
    - No pathways to facilitate cross-service/cross-system care planning for children and families
- Transition planning in and out of institutional settings is insufficient
    - Lack of continuity during the course of care (during admission, course of stay, return to community)
    - Burden falls on parents to manage successful transition
    - Schools often unprepared, unequipped
- Transition-Age Youth are underserved by both the child and adult systems and there is no mechanism to assure smooth transition into needed adult services and supports when aging out of the children's system

2. Review of Children receiving services out of state

- Reviewed demographics
- Reviewed financial summary
- Reviewed services and specialties of out of state placement
- Reviewed results from 2010 Iowa Child and Family Household Health Survey
- Identified how children are getting to out-of-home placement
    - Through systems (MH, DD, JJ, CW, Education)
    - More default than design
    - History of "unsuccessful" in-state placements

    - No in-state “specialized” capacity
    - In-state facilities “declined” admission due to capacity or service needs
- Considered likely treatment and support needs of children returning to Iowa
    - Care coordination for children who most likely have multiple challenges (*physical, emotional, behavioral, developmental and/or social)*
    - Multiple system and/or multiple service needs
    - Flexible in-community supports (home, school, neighborhood)
    - Specialized support of parents, guardians, caretakers and families
    - Specialized skills in engaging and working with children with multiple challenges (*physical, emotional, behavioral, developmental and social)*

3. Review of best and promising practices

In-state

- Community Circle of Care in Northeast Iowa
- Central Iowa Systems of Care

Other States or Jurisdictions

- Milwaukee, Wisconsin: Wraparound Milwaukee
- Alaska: “Bringing the Kids Home”
- Minnesota: Children’s Mental Health System Redesign
- Kansas: Transition to a Mental Health System of Care
- Massachusetts: Children’s Behavioral Health Initiative

Other

- Services for Transition-Age Youth (entering adulthood)
- Services for children with/at risk for co-existing mental health and developmental disabilities
- Building Systems of Care
- Family Support Services
- Health Home model of care
- Building Crisis Systems of Care
- Multi-Systemic Therapy
- SAMHSA: Good and Modern Systems
- American Academy of Pediatrics Mental Health Competencies for Primary Care
- NAMI: Child and Youth Mental Health Services and Support Array
- National Center for Mental Health and Juvenile Justice: Advances and Innovations

4. A vision for Children and Families in Iowa

The Workgroup developed the following definition of **Iowa Systems of Care for Children:**

A child and family-driven, cross-system spectrum of effective, community-based services, supports, policies and processes for children, from birth – young adulthood, with or at risk for physical, emotional, behavioral, developmental and social challenges and their families, that is organized into a flexible and coordinated network of resources, builds meaningful partnerships with families, children, and young adults, and addresses their cultural and linguistic needs, in order for them to optimally live, learn, work, and recreate in their communities, and throughout life.

The cross-systems, whole-health definition is a call not just to the Children and Youth Mental Health and Disability Service system and providers, but to all child-serving systems within our communities to adopt a high-level view and a shared vision for engaging, serving, educating and supporting children and their families. It requires that we eliminate isolated "silos" of thinking and practice, recognize the interdependence of each system and service on the other, the need to coordinate across funding streams, and that we collectively commit to meaningful partnerships with children and families in every aspect of service delivery in order to optimize care and outcomes.

The vision of the Children's Disability workgroup is that the Children and Youth Mental Health and Disability Services system and providers lead in the delivery of services that are:

Coordinated—at a child and family level, at a community level, and at a systems level, mental health and disability services are delivered with attention to integration, fluidity, efficiency, transparency, and child and family outcomes
Family and Youth-Driven—focused on the wishes, needs and strengths of a child and his/her family and delivered through the optimal mix of natural, informal and formal services and supports
Competent—able to address the unique cultural and linguistic needs of children and families, and eliminating disparities in care.
Developmentally-driven and evidence-based—to effectively engage and serve children and youth from birth through young adulthood through the use of proven and promising prevention, early intervention and treatment practices.
Flexible, nimble, nuanced, varied, specialized—through collaboration, shared decision-making, use and persistence in assuring children and families get <u>what they need</u> to optimally live, learn, work, and recreate in their communities, and throughout life.
Delivered "where kids are"—home, school and community-based supports designed to help kids succeed in their environment in ways that are most natural, normal, comfortable, usable and sustainable
Accessible—time-sensitive access across a full spectrum of services and supports promotes interventions that are upstream, available, welcomed and least-restrictive.

Attentive to the journey and needs of parents, guardians, caretakers and families—through support and assistance in navigation, bringing voice and choice to decision-making, engaging with other parents and families

Draft Recommendations

The workgroup believes:

- A functional system (Systems of Care model) is required in order to sustain an effort to serve children in Iowa. Short term efforts can bring a group of children home, but development of key elements of a system are required in order to sustain any effort to effectively serve children in Iowa.

This set of recommendations includes a specific short term strategy to bring kids back to Iowa. The short term strategy would be structured so that it begins to develop the types of services that would be implemented statewide. The recommendations also include specific services and strategies that will create the infrastructure necessary for the Systems of Care model.

Recommendations

1. **Care Coordination: Implement a Health Home model of care.** Systems of Care require comprehensive, person-centered care coordination. Iowa's current Children's Mental Health System lacks access to care coordination and navigation for families. The health home model shares the same core standards for 'whole person', and person-centered planning and coordination, is well-aligned with the Systems of Care principles and is a specific strategy to implement this necessary component of the system. Health Home is a new Medicaid option that has 90% federal match for the first two years of operation.

2. **Parent Peer Support: Implement parent peer support as an integrated component of the Health Home.** Parent support is a core element of the Systems of Care model. The lack of parent peer support is a significant gap in Iowa's current system. This element would be built into the Health Home.

3. **Implement a comprehensive Crisis System**, that includes (but is not limited to) the following two key components:

    - Crisis Intervention – An array of crisis services would be provided and would be coordinated by the Health Home. This includes crisis planning, 24/7/365 telephonic support, urgent appointments, office-based crisis intervention (with a resolution-focus), and home, school and community-based mobile crisis intervention.
    - Crisis Stabilization – Short term residential or non-residential services that provide services needed to stabilize in a time of crisis (can include short term in or out of home respite, maybe small home like settings or

residential, but less than one week). Individualized and person-centered (rather than program-centered), goal oriented, and brief with a thoughtful 'front and back door'.

4. **Intensive In-Home/School Treatment:** These services are available through the Behavioral Health Intervention Services (BHIS). These services would be a key component of treatment plans developed and coordinated by the Health Home and care team. Some enhancements to the services may be needed to serve the children with the highest or more unique needs.

5. **Ensure a more flexible and accessible sub-acute level of care.** Iowa's Psychiatric Medical Institutions for Children (PMICs) can be considered a sub-acute level of care. The Workgroup believes this level of care should be:

    - Flexible – A child can go back for brief stays when needed
    - Accessible – no waiting list for admission
    - Used more strategically for the highest need children – greater navigation, coordination, service delivery and early intervention should be developed to ensure this scarce resource is available for the highest need children at the time it is needed
    - Available, along with created community treatment options, to serve children current going out of state
    - Function with shorter lengths of stay with enhanced community services and early intervention to prevent admissions and enable earlier discharge.
    - Fully integrated within the array and management of the full system

    Current reimbursement models and separation of PMIC services from the rest of the managed care mental health system are barriers to meeting these goals. The workgroup recommends these issues be considered as part of the transition of PMICs to managed care.

6. **Implement a specific short term strategy to bring children home from out of state placements based on the recommendations above.** This serves a dual purpose of bringing children home, while beginning to develop the strategies recommended above. This strategy is designed to be delivered through the managed care plan. This strategy includes:

    - Issue one or more Requests for Proposals (RFP) that will serve children currently out of state and those at risk of out-of-state placement in Iowa.

- The RFP will seek proposals from providers or partnerships of providers to serve these children and develop services necessary to meet their needs with a 'community first' focus.
- The proposals would address the development of a health home model for care coordination and peer support, crisis services, intensive in-home services, creation of innovative community based strategies, and subacute services that meet the goals described above.
- The RFP will consider innovative reimbursement methods, including performance based models.
- The RFP will include outcome measures aligned with the Workgroup's defined outcomes.
- The RFP must address the needs of rural and urban areas of the state.
- Timeline: RFP would be issued by the Iowa Plan soon after 7/1/12, after PMIC services transition to the Iowa Plan. FY 2013 (7/1/12 – 6/30/13) would include RFP Issuance, development of the proposals and submission and award. Implementation spring of 2013.
    i. The Children's Disability Workgroup will continue meeting over this time period. The Workgroup would be continuing to define the requirements of the recommended strategies above. That work would inform the RFP process.